MIRAMAR

2020 OPEN ENROLLMENT

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CONTACT INFORMATION

COVERAGE	CARRIER	CONTACT INFORMATION
Human Resources	Human Resources Department	(954) 602-3836
Employee Benefits Enrollment	Bentek	(888) 523-6835 www.Mybentek.com/cityofmiramar E-mail: support@mybentek.com
Medical	Aetna	(855) 281-8858 Aetna.com
Pharmacy & Mail Order Program	Aetna Rx Home Delivery	(888) 792-3862 www.aetna.com
Claims Resource Center	Aetna Member Services	(855) 281-8858
Dental	Delta Dental	DPPO: (800) 521-2651 DHMO: (800) 422-4234 www.Deltadentalins.com
Vision	EyeMed	(866) 723-0513 www.Eyemed.com
Health Savings Account	Payflex	1-844-729-3539 www.Payflex.com
Flexible Spending Accounts	AmeriFlex	(888) 868-3539 www.myameriflex.com
Life and Disability	The Standard	(800) 368-1135 www.Standard.com
Supplemental Insurance	Aflac	(800) 433-3036 www.Aflacgroupinsurance.com (954) 439-4283
Employee Assistance Program	Aetna Resources for Living	(888) 238-6232 www.Mylifevalues.com
Standard Travel Assistance	Standard/UHC Global	(800) 527-0218 E-mail: assistance@uhcglobal.com
Legal Assistance Services	Preferred Legal	(888) 577-3476 www.Preferredlegal.com
Wellness Program	Vitality	(877) 224-7117 www.powerofvitality.com

INTRODUCTION

As a City of Miramar employee, you help shape the quality of life for our residents, and you play a vital role in fulfilling the City's mission. The City's high-quality, comprehensive benefits are among the rewards you receive in return as part of your total compensation package. Your health and welfare benefits program provides both choice and value to meet your needs.

For the 2020 plan year, the City of Miramar has worked hard to offer a rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our employees healthy and secure. We understand that your situation is unique, and the City of Miramar is offering a benefits package with many possible choices - one that can be shaped and molded by you, to fit your needs.

We hope this enrollment booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.

*This enrollment booklet is a summary description of your City of Miramar benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment.

SUMMARY OF BENEFITS AND COVERAGE

A Summary of Benefits & Coverage (SBC) for the medical plans will be available to all employees during open enrollment. The summary is an important item in understanding the benefit options.

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be obtained and reviewed by contacting the Human Resources Department. If there are questions about the plan offerings or coverage options, please contact the Human Resources Department or visit www.mybentek.com/cityofmiramar

A PASSIVE ENROLLMENT

If you are changing your coverage, you will be required to make a benefits election during Open Enrollment in order for your new coverage to be effective on January 1, 2020. If you are not changing your existing coverage, you do not need to make an election through BenTek. **The exception to this is if you are interested in participating in a Health Care or Dependent Care Flexible Spending Account (FSA). FSAs do not automatically restart; they MUST be re-elected every year.**

Health Flexible Spending Account and Limited Health Flexible Spending Account maximum increased from $2,650 to $2,700

Increased Health Savings Account contribution from $1,350/2,700 to $1,400/$2,800. Deductible levels will still be fully funded into the Health Savings Account. Contributions will be prorated for new hires based on date of hire.

WHAT'S NOT CHANGING 2020

MEDICAL INSURANCE

The City will continue to offer medical coverage through Aetna, with no change in plan designs for the following options:
Aetna Health Network Only (HNO)
Aetna Managed Choice (POS)
Aetna High Deductible Health Plan (HDHP)
Payflex Health Savings Account

DENTAL INSURANCE

The City will continue to offer dental insurance designs for the following options:
Delta Dental PPO Plan
Delta Dental Care HMO

VISION INSURANCE

The City will continue to offer vision coverage through EyeMed Vision Care.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Employees are required to re-elect any and all FSA enrollment elections for the 2020 calendar year.

THE AFFORDABLE CARE ACT (ACA) 1095C FORM

All employees who participated in one of the City's Aetna Medical Plans during 2019 will receive a 1095C form in the mail from the City to file with their 2019 tax return. These forms will be mailed out around same time as the W-2 forms.

ONLINE ENROLLMENT

The City provides employees with an online benefits enrollment platform through BenTek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual open enrollment period, new hire orientation, or qualifying events.

Accessible 24 hours a day throughout the year, employees may log in to:

- Review comprehensive information regarding benefit plan(s)
- View and print an outline of benefit elections for employee and dependent(s)
- Gain access to important forms
- Find insurance carrier links
- Report qualifying life events
- Review and make changes to life insurance beneficiary designations

TO ACCESS THE EMPLOYEE BENEFITS CENTER

Log on to **www.mybentek.com/cityofmiramar**

- Sign in using a previously created account or click "Create an Account" to set up a username and password.
- If you've forgotten your username/password, click on the link "Forgot Username/Password" and follow the instructions.
- Once logged on, navigate to the menu in order to review current elections, learn about benefit options, and make elections, changes or beneficiary designations

For technical issues directly related to using the EBC please call (888) 5-BenTek (523-6835) or email BenTek Support at support@mybentek.com, Monday through Friday, during regular business hours from 8:30 a.m. to 5 p.m.

TO ACCESS GROUP INSURANCE BENEFITS ONLINE

Log on to: **www.mybentek.com/cityofmiramar**

Please Note: Link must be addressed exactly as written. Due to security reasons, the website cannot be accessed by Google or other search engines.

BENTEK IS MOBILE FRIENDLY!

You can access BenTek using any device such as a Smartphone, Tablet, Computer etc.

QUALIFYING EVENTS

IRS CODE SECTION 125

Premiums for medical, dental, vision insurance and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependent(s) experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse, or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and due to the qualifying event.

EXAMPLES OF QUALIFYING EVENTS:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Employee, spouse or dependent(s) terminate or start employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)

IMPORTANT RULES REGARDING QUALIFYING EVENTS

Employees who experience a qualifying event must contact the Human Resources Department within 30 days to make the appropriate changes to coverage. Beyond 30 days, requests will be denied and the employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of the employee or dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes are effective on the first of the month following the Qualifying Event and receipt of all required documentation.

In all cases possible, employees should notify Human Resources of the Qualifying Event prior to the event date. Newborns are effective on the date of birth and marriage is effective on the date of occurrence. Cancellations will be processed at the end of the month. In the event of death, coverage will terminate the date following the death. Employees will be required to furnish valid documentation supporting a change in status or Qualifying Event.

ELIGIBILITY RULES
GROUP INSURANCE ELIGIBILITY

EMPLOYEE ELIGIBILITY

All Full-Time and Permanent Part-Time Employees are eligible for coverage.

- Employees hired from the 1st to the 15th of the month are eligible for coverage the first day of the next month.
- Employees hired from the 16th to the 31st of the month are eligible for coverage the first day of the next subsequent month.
- IAFF employees are eligible for medical, dental and vision coverage under the IAFF Health Trust. For information regarding premium rates and plan documents, contact the IAFF Health Trust and/or IAFF Union representative.

PART-TIME EMPLOYEE ELIGIBILITY

Part-Time Benefit-Eligible employees are eligible for the following health plan benefits:

- Medical HMO options
- Dental HMO option
- Vision
- Life Insurance
- FSA

TERMINATION

If an employee separates employment from the City, health insurance will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

EMPLOYEE OPT-OUT

Effective January 1, 2020, Full-Time employees who opt-out of the City's group medical insurance plan and who meet the federal legislative requirements for a "conditional opt-out payment" shall receive the opt-out incentive in the amount of $215.80 per pay period ($5,610.80 annually if receiving opt-out payment for the entire 2020 Plan Year). Those who enroll in individual or marketplace plans or do not otherwise meet the requirements for a "conditional opt-out" payment shall not be eligible for any opt-out payments. To participate in the "conditional opt-out" benefit, employees are required to provide Human Resources with proof of current medical insurance indicating name of employee and employee's tax dependents **before November 28, 2019** (or by the designated deadline for new hires or qualifying event changes throughout the plan year). Retroactive funding will not be processed if an employee did not timely enroll or re-enroll in this program for the New Year. Please contact Human Resources for additional details on required forms and acceptable documentation.

DEPENDENT ELIGIBILITY

A dependent is defined as the legal spouse or domestic partner and/or dependent child(ren) of the participant or spouse or domestic partner. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

DEPENDENT AGE REQUIREMENTS

MEDICAL COVERAGE

A dependent child may be covered through the end of the calendar year in which the dependent child turns age 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the dependent child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

DENTAL COVERAGE

A dependent child may be covered to the end of the calendar year in which the dependent child turns age 19; or to the end of the calendar year in which the dependent child turns age 30, if a full-time or part-time student.

VISION COVERAGE

A dependent child may be covered through the end of the calendar year in which the dependent child turns age 26; or to the end of the calendar year the dependent child turns age 30 if unmarried, no dependents of his or her own, is a resident of Florida, or a part-time or full-time student.

DISABLED DEPENDENTS

Coverage for an unmarried dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- The dependent is primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group medical plan; and
- The dependent has been continuously insured; and
- Coverage began prior to age 26

Proof of disability will be required upon request.

TAXABLE DEPENDENTS

Employees covering adult children under certain group insurance plans may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the dependent child reaches age 26. Beginning January 1 of the calendar year in which the dependent child is 26 through the end of the calendar year in which the dependent child reaches age 30, employees will be charged an additional premium on a post-tax basis to continue coverage for such dependents. In addition, imputed income applies and will be assessed each payroll period based on the tier enrolled in which an over-age dependent is covered.

DOMESTIC PARTNER

Domestic Partners may be eligible to participate in the City's Group Insurance Plans and are required to complete a declaration of Domestic Partnership. The IRS guidelines state that an employee may not receive a tax advantage on any portion of premium paid related to Domestic Partner coverage unless specific IRS guidelines have been met. Employees insuring a Domestic Partner and/or child dependents of a Domestic Partner may be required to pay "imputed income tax" on premium deductions and should consult their tax professional.

Please contact the Human Resources Department for more information.

MEDICAL

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Through the plans offered by the City of Miramar, **all covered individuals and family members are eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**

COVERED PREVENTATIVE CARE SERVICES

Below is a subset of routine preventative/wellness services that are included in the plans at no cost. For more detailed information on available preventative care services, visit the CDC website at www.cdc.gov/prevention. For routine wellness services to be covered at no cost, they must coincide with the CDC recommended preventative care schedule and routine in nature. Preventative care services run on a 12 month schedule and do not reset as the plan year re-starts. Please contact the insurance carrier for further details.

- ✔ Routine Physical Exam
- ✔ Well Baby & Child Care
- ✔ Well Woman Visits
- ✔ Immunizations
- ✔ Routine Bone Density Test
- ✔ Routine Breast Exam
- ✔ Routine Gynecological Exam
- ✔ Screening for Gestational Diabetes
- ✔ Routine Digital Rectal Exam
- ✔ Routine Colonoscopy
- ✔ Routine Colorectal Cancer Screening
- ✔ Routine Prostate Test
- ✔ Routine Lab Procedures
- ✔ Routine Mammograms
- ✔ Routine Pap Smear
- ✔ Smoking Cessation
- ✔ Testing for HPV and HIV

TERMS TO REMEMBER

ANNUAL DEDUCTIBLE

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

COPAYS AND COINSURANCE

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount, and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the provider.

OUT-OF-POCKET MAXIMUM

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays and coinsurance.

PLAN TYPES

HMO network that allows you to select a Primary Care Physician (PCP) who coordinates your health care. Referrals are not required to see a specialist.
POS Combines aspects of a PPO and HMO
HDHP A plan that has higher annual deductibles in exchange for lower premiums.

AETNA HEALTH NETWORK ONLY

SUMMARY OF COVERAGE

NETWORK	HEALTH NETWORK ONLY
Calendar Year Deductible	**In- Network**
Single Family	N/A N/A
Out of Pocket Maximum	
Single Family	$3,850 / $2,500 RX $7,700 / $5,000 RX
Coinsurance	
Member Responsibility	N/A
Physician Services	
Primary Care Visit Specialist Visit Spinal Manipulation Therapy (60 Visits per CY)	$20 copay $40 copay $25 copay
Imaging Services	
Clinical Lab (Blood Work) * X-rays Advanced Imaging (MRI, PET, CT)	$0 $0 $100 copay per scan
Hospital Services	
Inpatient Hospital (per admission) Outpatient Surgery Physician Services at Hospital Emergency Room (copay waived if admitted) Urgent Care	$250 copay $150 copay $0 $250 copy $75 copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospitalization (per admission) Outpatient Services (per visit)	$250 copay $20 Copay
Prescription Drugs (RX)	
Generic - Tier 1 Preferred Brand Name - Tier 2 Non-Preferred Generic and Brand Name - Tier 3 Specialty Drugs Mail Order Drug (90 Day Supply)	$10 copay $30 copay $60 copay 25% coinsurance $20/$60/$120 copay

Quest Diagnostics and LabCorp are Aetna's preferred labs for bloodwork. When using a lab other than Quest and LabCorp, please be sure to confirm they are contracted with Aetna's Health Network Only network prior to receiving services.

Out of Network services are not available under this plan except for true emergency services.

AETNA MEDICAL – HDHP

NETWORK	HDHP HEALTH NETWORK ONLY
Calendar Year Deductible	**In- Network**
Single	$1,400*
Family	$2,800*
Out of Pocket Maximum	
Single	$2,800
Family	$5,600
Miramar Contribution to Payflex Health Savings Account	
Individual/Family	Up to $1,400/$2,800 (proration rules apply)
Coinsurance	
Member Responsibility	10%
Physician Services	
Primary Care Visit	10% after deductible
Specialist Visit	10% after deductible
Spinal Manipulation Therapy (60 Visits per CY)	10% after deductible
Imaging Services	
Clinical Lab (Blood Work)**	10% after deductible
X-rays	10% after deductible
Advanced Imaging (MRI, PET, CT)	10% after deductible
Outpatient Surgery at Surgical Center	10% after deductible
Physician Services at Surgical Center	10% after deductible
Hospital Services	
Inpatient Hospital (per admission)	10% after deductible
Outpatient Surgery	10% after deductible
Physician Services at Hospital	10% after deductible
Emergency Room (copay waived if admitted)	10% after deductible
Urgent Care	10% after deductible
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospitalization (per admission)	10% after deductible
Outpatient Services (per visit)	10% after deductible
Prescription Drugs (RX)	
Generic - Tier 1	$10 copay after deductible
Preferred Brand Name - Tier 2	$30 copay after deductible
Non-Preferred Generic and Brand Name - Tier 3	$60 copay after deductible
Specialty Drugs	25% coinsurance after deductible
Mail Order Drug (90 Day Supply)	$20/$60/$120 copay after deductible

** The City will fully fund the applicable deductible through a Health Savings Account. Proration rules apply to new hires.*

*** Quest Diagnostics and LabCorp are Aetna's preferred labs for bloodwork. When using a lab other than Quest and LabCorp, please be sure to confirm they are contracted with Aetna's Health Network Only network prior to receiving services.*

Out of Network services are not available under this plan except for true emergency services.

AETNA MEDICAL – POS

NETWORK	MANAGED CHOICE POS	
Calendar Year Deductible	**In- Network**	**Out of Network**
Single Family	$500 $1,000	$750 $1,500
Out of Pocket Maximum		
Single Family	$3,850/$2,500 RX $7,700/$5,000 RX	$2,000/$2,500 RX $4,000/$5,000 RX
Coinsurance		
Member Responsibility	0%	20%
Physician Services		
Primary Care Visit Specialist Visit Spinal Manipulation Therapy	$25 copay $50 copay $25 copay	20% after deductible 20% after deductible 20% after deductible
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Blood Work)* X-rays Advanced Imaging (MRI, PET, CT) Outpatient Surgery at Surgical Center Physician Services at Surgical Center	100% after deductible 100% after deductible $100 copay after deductible 100% after deductible	20% after deductible 20% after deductible 20% after deductible 20% after deductible
Hospital Services		
Inpatient Hospital (per admission) Outpatient Surgery Emergency Room (copay waived if admitted) Urgent Care	$250 copay after deductible $100 copay after deductible $300 copay $75 copay	20% after deductible 20% after deductible $300 copay 20% after deductible
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospitalization (per admission) Outpatient Services (per visit)	$250 copay after deductible $25 copay after deductible	20% after deductible 20% after deductible
Prescription Drugs (RX)		
Generic - Tier 1 Preferred Brand Name - Tier 2 Non-Preferred Generic and Brand Name - Tier Specialty Drugs Mail Order Drug (90 Day Supply)	$10 copay $30 copay $60 copay 25% coinsurance $20/$60/$100 copay	30% of submitted cost; after copay 30% of submitted cost; after copay 30% of submitted cost; after copay Not Covered Not Covered

** Quest Diagnostics and LabCorp are Aetna's preferred labs for bloodwork. When using a lab other than Quest or LabCorp, please be sure to confirm they are contracted with Aetna's Open Access Managed Choice network prior to receiving services.*

*** Out of Network Services are subject to balance billing. Please see the Certificate of Coverage for full details on how out of network charges are processed. Mail order and Specialty drugs are not covered out of network.*

Mail order and specialty drugs are not covered out of network.

MEDICAL

BI-WEEKLY PAYROLL DEDUCTIONS

HMO	GAME*	PBA	PART-TIME PERMANENT	UNREP
Employee Only	$0.00	$15.00	$15.00	$15.00
Employee + Spouse	$145.44	$168.40	$168.40	$168.40
Employee + Child(ren)	$159.34	$172.08	$172.08	$172.08
Employee + Family	$253.02	$273.26	$273.26	$273.26

POS	GAME*	PBA	PART-TIME PERMANENT	UNREP
Employee Only	$0.00	$15.00	N/A	$15.00
Employee + Spouse	$212.93	$279.47	N/A	$226.24
Employee + Child(ren)	$254.86	$354.59	N/A	$265.94
Employee + Family	$404.70	$563.07	N/A	$422.30

HDHP HMO	GAME*	PBA	PART-TIME PERMANENT	UNREP
Employee Only	$0.00	$0.00	$0.00	$0.00
Employee + Spouse	$122.17	$141.46	$141.46	$141.46
Employee + Child(ren)	$133.84	$144.55	$144.55	$144.55
Employee + Family	$212.53	$229.54	$229.54	$229.54

IAFF employees are eligible for coverage under the IAFF Health Trust. For information regarding premium rates and plan documents, contact the IAFF Health Trust representative.

** Employees covered under the G.A.M.E. Collective Bargaining Agreement (CBA) must complete an annual preventive care physical by the deadline indicated in the CBA in order to avoid an increase in premium of $15.00 per paycheck.*

WELLNESS
POWERED BY VITALITY

The City of Miramar is devoted to health and wellness and continues to embrace health plans that inspire employees and their dependents to live a healthy and active lifestyle. To promote health and wellness, the City sponsors Wellness Wednesday events every month, in addition to fun events throughout the year.

Through the Vitality platform, benefit-eligible employees will experience a comprehensive, interactive and personalized wellness program that makes it easy to make healthy choices and be rewarded for it.

To register, visit www.powerofvitality.com to begin your personal wellness journey. There are multiple ways to engage in wellness through the Vitality platform, which turn in Vitality Points which can be cashed in for Rewards such as gift cards or merchandise.

For additional information, visit www.powerofvitality.com or contact Vitality Customer service at (877) 224-7117

Watch for upcoming health and wellness events and join us in becoming one of the healthiest cities in Florida!

DENTAL

DELTA DENTAL PPO COVERAGE

The City of Miramar offers dental insurance through Delta Dental to all benefit-eligible employees. The cost per pay period for coverage is listed in the premium table. A brief summary of benefits is provided on page 16, and the cost per pay period for coverage is listed in the table on page 18. For more detailed information about the dental plans, please refer to Delta Dental's benefits summary or contact Delta Dental's customer service.

IN-NETWORK BENEFITS

The PPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is **Delta Dental PPO** network. These participating dental providers have contractually agreed to accept Delta Dental's contracted fee or "approved amount". This fee is the maximum amount a Delta Dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Please Note: If a member is not able to use a Delta Dental PPO provider, then services can be received from a Delta Dental Premier Provider. Delta Dental Premier Providers are considered out-of-network dentists. These dentists have agreed to accept Delta Dental's Maximum Plan Allowance (MPA) for each single procedure; however, the provider may still bill for the difference of the MPA and the Premier Dental Agreement amount. ***The member is responsible for verifying whether the treating dentist is a PPO Dentist or Premier Dentist.***

OUT-OF-NETWORK BENEFITS

Out-of-network benefits are used when members receive services by a non-participating Delta Dental provider. Delta Dental reimburses out-of-network services based on what it determines is the Maximum Plan Allowance (MPA). The MPA is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member will pay the out-of-network benefit plus the difference between the amount that Delta Dental reimburses (MPA) for such services and the amount charged by the dentist. This is known as balance billing. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

CALENDAR YEAR DEDUCTIBLE

The dental PPO plan requires a $50 individual or a $100 family deductible to be met for in-network or out-of- network services before most benefits will begin. The deductible is waived for preventative and diagnostic services.

CALENDAR YEAR BENEFIT MAXIMUM

The maximum benefit the dental PPO plan will pay for each covered member is $1,500 for in-network or out-of-network services combined. Diagnostic and preventative services accumulate towards the benefit maximum.

PLAN FEATURES	IN NETWORK	OUT OF NETWORK
Individual Deductible	$50	$50
Family Deductible	$100	$100
Waived for Preventive Services	Yes	Yes
Calendar Year Deductible	$1,500	$1,500
Preventive Care	**100%**	**100%***
Routine Oral Exam	100%	100%*
Routine Cleaning (2 per calendar year)	100%	100%*
Bitewing X-rays (2 per calendar year)	100%	100%*
Basic Procedures	**80%**	**80%***
Simple Extractions	80%	80%*
Endodontics & Periodontics	80%	80%*
Major Procedures	**60%**	**60%***
Crowns	60%	60%*
Dentures	60%	60%*
Bridges	60%	60%*
Adult & Child Orthodontia	**50%**	**50%***
Lifetime Deductible	$50 per member	
Benefit Maximum	$1,000	
Benefit – Adults and Children	50% after deductible	

** Out of Network Services are subject to balance billing. Please see the Certificate of Coverage for full details on how out of network charges are processed.*

DENTAL

DELTA DENTAL DHMO COVERAGE

IN-NETWORK BENEFITS

The DHMO dental plan is an in-network only plan that requires all services be received by a Primary Dental Provider (PDP). Employee and dependent(s) may select any participating dentist in the **DeltaCare USA** network to receive covered services. There is no coverage for services received out-of-network.

The DHMO plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following page. Please refer to the plan's summary of coverage document for a detailed listing of charges and what is covered.

OUT-OF-NETWORK BENEFITS

The DHMO plan does not cover any services rendered by out-of-network facilities or providers.

KEY POINTS TO NOTE

- Each covered family member may receive two (2) routine cleanings per calendar year (1 every 6 months) covered under the preventive benefit. Additional cleanings are available at the charge of a copay (oral surgeon, endodontics, periodontist or pediatric dentistry) within the network.
- Waiting periods and age limitations may apply for some services.
- Pediatric services are limited to children up to age seven (7), unless medical necessity is approved by Delta Dental.

Class I: Preventive Services	Code	In-Network
Routine Oral Exam	0120	$0
Routine Cleaning (1 Every 6 Months)	1110/1120	$0
Bitewing X-rays (4 films, 1 Series Every 6 Months)	0274	$0
Class II: Basic Services	**Code**	**In-Network**
Fillings (Amalgam; 3 Surface: Primary or Permanent)	2160	$0
Fillings (Composite, 3 Surface: Anterior/Posterior)	2332/2393	$0 copay/$65 copay
Deep Cleaning (1 Per Year)	4355	$50 copay
Periodontal Maintenance (1 Every 6 Months)	4910	$35 copay
Class III: Major Services	**Code**	**In-Network**
Crowns (Porcelain Fused to High Noble Metal)	2750	$335 copay
Dentures	5110/5120	$285 copay
Bridges	6241	$255 copay
Class IV: Orthodontia (Lifetime Maximums) Services	**Code**	**In-Network**
Benefit – Child (To Age 19)	8070/8080	$1,900
Benefit – Adults and Dependent Children (Ages 19-25)	8090	$2,100
Evaluation	8660	$25 copay

BI-WEEKLY
PAYROLL DEDUCTIONS

COVERAGE TIER	DPPO	DHMO
Employee Only	$0	$0
Employee + Spouse	$8.81	$2.11
Employee + Child(ren)	$7.20	$2.41
Employee + Family	$19.04	$5.42

IAFF employees are eligible for coverage under the IAFF Health Trust. For information regarding premium rates and plan documents, contact the IAFF Health Trust representative.

VISION
EYEMED VISION

Employees have an opportunity to purchase vision insurance benefits through EyeMed vision.

IN-NETWORK BENEFITS

The vision plan offers employees and dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, select any network provider who participates in the EyeMed Insight Network. Basic vision examinations and optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen.

OUT-OF-NETWORK BENEFITS

Employees and dependent(s) may also choose to receive services from vision providers who do not participate in the EyeMed Insight Network. When going out of network, the provider will require payment at the time of appointment. EyeMed will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

COVERAGE TIER	PAYROLL DEDUCTION	
Employee Only	$2.43	
Employee + Spouse	$4.63	
Employee + Child(ren)	$4.87	
Employee + Family	$7.07	
Plan Features	**In-Network**	**Out of Network Reimbursement**
Vision Exam	$10 copay	up to $40
Materials	$10 copay	Based on type of service
Lenses		
Single	$10 copay	up to $30
Bifocal	$10 copay	up to $50
Trifocals	$10 copay	up to $70
Progressive	$75 copay	up to $50
Frames	$110, 20% off balance over $110	up to $77
Elective Contact Lenses	$110, 15% off balance over $110	up to $110
Medically Necessary Contact Lenses	Paid in full	up to $210
Frequency of Services		
Exam	12 months	
Lenses	12 months	
Frames	24 months	
Contacts	12 months	

Vision benefit is 100% employee paid
IAFF employees are eligible for coverage under the IAFF Health Trust. For information regarding premium rates and plan documents, contact the IAFF Health Trust representative.

EMPLOYEE ASSISTANCE PROGRAM

The City of Miramar provides supplemental health and wellness programs for employees and their dependents. Aetna's Resources for Living Employee Assistance Program provides employees and family member(s) with professional counseling for a variety of problems that affect quality of life. All EAP counselors are professionally trained and are certified/licensed in their fields. Qualified counselors are available 24 hours a day, 7 days a week, at (888) 238-6232. The EAP also allows for three (3) face-to-face in-person sessions with a counselor for short-term problem resolution. Conditions that require a long-term treatment solution may be referred to employee's medical plan.

WHAT IS AN EMPLOYEE ASSISTANCE PROGRAM?

The City cares about employee's well-being on and off the job and provides an EAP to give employees a comfortable, safe place to turn for help with problems such as:

- Relationship Issues
- Substance Abuse
- Critical Incident Stress Debriefing
- Childcare Consultation
- Eldercare Consultation
- Marital Problems
- Financial and Legal Issues
- Stress Management
- Parenting Problems
- Identity Theft

ARE YOUR SERVICES CONFIDENTIAL?

Yes. Receipt of EAP services is completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor will not, however, receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

AETNA | AETNA RESOURCES FOR LIVING CUSTOMER SERVICE

(888) 238-6232 | www.mylifevalues.com

Username: City of Miramar | Password: eap

PAYFLEX

HEALTH SAVINGS ACCOUNT (HSA)

HOW IT WORKS

A Health Savings Account (HSA) is a health care account and savings account in one. The main purpose of this account is to offset the cost of a qualifying high deductible health plan (HDHP) and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

This is a "portable" account. You own your HSA! It is included in your employee benefits package, but after you set up your account, it is yours to keep, even if you change jobs or retire.

Once your HSA is established, money is contributed to your account by the City of Miramar, and/or you, and you and your dependents can then use your HSA dollars tax-free to pay for eligible health care expenses. You save money on expenses you're already paying for, such as doctors' office visits and prescription drugs.

BENEFITS OF AN HSA

HSAs benefit everyone who is eligible to have this account – single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

1 **Tax-free deposits**
The money contributed to your HSA isn't taxed (up to the IRS annual limit).

2 **Tax-free earnings**
Your interest and any investment earnings grow tax-free.

3 **Tax-free withdrawals**
The money used toward eligible health care expenses isn't taxed– ever.

HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA dollars.

Setting aside pre-tax dollars into your HSA means you decrease your tax liability and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket.

HSA CONTRIBUTION LIMITS AND CITY CONTRIBUTION LEVELS

The 2020 High Deductible Health Plan has a single deductible of $1,400 and a family deductible of $2,800.

The City of Miramar will fully fund the deductible in a PayFlex Health Savings Account for the full deductible amount of $1,400 for members who elect employee only coverage and $2,800 for any dependent level. New hires who enroll in the HDHP during the 2020 plan year will receive a prorated contribution to the Health Savings Account from the City of Miramar based on the quarter in which they are hired.

You may also contribute additional funds in your HSA up to the IRS contribution limit of $3,550 for Employee-Only and $7,100 for Family. Any amount you allocate to your Health Savings account will be deducted on a pre-tax basis, which will reduce your taxable income. The charts below highlight your maximum allowable contribution based on the City's contribution.

HDHP TIER LEVEL	2020 IRS CONTRIBUTION LIMIT	CITY MAXIMUM CONTRIBUTION	MAX ANNUAL CONTRIBUTION
Employee Only	$3,550	$1,400	$2,150
Employee + Spouse	$7,100	$2,800	$4,300
Employee + Child(ren)	$7,100	$2,800	$4,300
Employee + Family	$7,100	$2,800	$4,300
HDHP TIER LEVEL	**AGE 55 + 2020 IRS CONTRIBUTION LIMIT**	**CITY MAXIMUM CONTRIBUTION**	**MAX ANNUAL CONTRIBUTION**
Employee Only	$4,550	$1,400	$3,150
Employee + Spouse	$8,100	$2,800	$5,300
Employee + Child(ren)	$8,100	$2,800	$5,300
Employee + Family	$8,100	$2,800	$5,300

Employees will also have the option to purchase voluntary benefits from Aflac to help offset any potential cost from the high deductible health plan and minimize the use of the health savings account.

Refer to your HSA documentation for more information.

AMERIFLEX

FLEXIBLE SPENDING ACCOUNT (FSA)

The City of Miramar offers Flexible Spending Accounts (FSA) administered through AmeriFlex. The FSA plan year is from January 1 to December 31. If employee or family members have predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employees to set aside money from their paycheck for reimbursement of health care and daycare expenses that they regularly pay. The amount set aside is not taxed and is automatically deducted from the employee's paycheck and deposited into the FSA. During the year, the employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employees must re-elect the dollar amount they wish to have deducted each plan year.

Those participating in the medical flexible spending account plan can only enroll in the Aetna HNO or Aetna POS plan. Those enrolling in the Aetna HDHP plan will have access to an employer-funded Health Savings Account (HSA) and may opt to use a limited-purpose FSA. Couples with different employers must choose between an HSA or medical FSA for the household. The IRS prohibits a family from having both an FSA and HSA.

THE CITY OFFERS TWO TYPES OF FSAs:

HEALTH CARE REIMBURSEMENT FSA

The Health Care FSA covers medical, dental, and vision expenses that are not paid by insurance. This account allows participants to set aside up to an annual maximum of $2,700. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). You may not participate in the traditional Health Care Reimbursement FSA if enrolled in the HDHP plan. You may select the Limited FSA only (limited to dental and vision expenses only) explained in more detail on the following page.

THE DEPENDENT CARE FSA

Available to eligible employee for qualified dependent day care expenses that are necessary for employee and legal spouse, if married, to work. This account allows the participant to set aside up to an annual maximum of $5,000 if single or $2,700 if married and file a joint tax return, for work- related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note that if a family's income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return.

To qualify, dependents must be: A child under the age of 13, or a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in the participant's household.

FILING A CLAIM FORM

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one year.

DEBIT CARD

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities and most pharmacy retail outlets. AmeriFlex may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to AmeriFlex. This card will not expire at the end of the benefit year. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

LIMITED PURPOSE FSA

The City of Miramar is also offering a Limited Purpose Flexible Spending Account (FSA) administered by AmeriFlex for those enrolled in the High Deductible Health plan.
This plan is not available for the HNO or PPO plans.

The limited purpose FSA works the same way as the regular FSA except covered expenses are limited to other healthcare expense excluding medical expenses. Under a Limited Purpose FSA, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

Refer to your FSA documentation for more information.

LIFE INSURANCE

THE STANDARD

The City of Miramar provides basic term life insurance and accidental death and dismemberment benefits at no cost to you. The AD&D benefits pay in addition to the basic term life insurance if death occurs as a result of an accident. The AD&D benefit amount is equal to the basic term life benefit.

YOUR LIFE AND AD&D BENEFITS EXPLAINED

If a member who has a $50,000 death benefit expires due to natural causes or as a result of an illness or disease, his or her beneficiary will receive $50,000. If a member with a $50,000 death benefit expires as a result of a car accident or other accident, their beneficiary will receive $100,000 in total. The policy will pay $50,000 for the life insurance benefits and an additional $50,000 for the accidental death and dismemberment benefit since the death occurred as a result of an accident.

Please Note: Employees who do not smoke will also be eligible for an additional $20,000 benefit at no cost. A non-smoker affidavit must be received by Human Resources in order to qualify.

EMPLOYEE CLASSIFICATION	BENEFIT AMOUNT
Class 1: City Managers	1.5 x salary to max of $330,000
Class 2: Unrepresented Employees	1.5 x salary to max of $280,000
Class 3: IAFF Employees	1 x salary to max of $100,000
Class 4: PBA Employees	Flat benefit amount of $100,000
Class 5: GAME Employees	1.5 x salary to max of $150,000
Class 6: Part-time Employees	$5,000
THE FOLLOWING SHOWS HOW MUCH BENEFITS ARE REDUCED AT CERTAIN AGES:	
Age Band	Benefit Reduction
65	33%
70	55%

For more info on rates and rate calculation, please refer to The Standard Insurance Benefit Booklet. Members age 70 and above should refer to the Standard benefit booklet.

BI-WEEKLY
PAYROLL DEDUCTIONS

Coverage Amount	Employee's Age as of last January 1										
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*	75+*
$10,000	0.25	0.33	0.42	0.71	1.20	1.91	2.82	4.15	6.56	9.07	10.43
$20,000	0.50	0.66	0.83	1.41	2.41	3.82	5.65	8.31	13.13	18.15	20.86
$30,000	0.75	1.00	1.25	2.12	3.61	5.73	8.47	12.46	19.69	27.22	31.29
$40,000	1.00	1.33	1.66	2.82	4.82	7.64	11.30	16.62	26.25	36.29	41.72
$50,000	1.25	1.66	2.08	3.53	6.02	9.55	14.12	20.77	32.82	45.36	52.15
$60,000	1.50	1.99	2.49	4.24	7.23	11.46	16.95	24.92	39.38	54.44	62.58
$70,000	1.74	2.33	2.91	4.94	8.43	13.38	19.77	29.08	45.94	63.51	73.01
$80,000	1.99	2.66	3.32	5.65	9.64	15.29	22.60	33.23	52.50	72.58	83.44
$90,000	2.24	2.99	3.74	6.36	10.84	17.20	25.42	37.38	59.07	81.66	93.87
$100,000	2.49	3.32	4.15	7.06	12.05	19.11	28.25	41.54	65.63	90.73	104.30
$110,000	2.74	3.66	4.57	7.77	13.25	21.02	31.07	45.69	72.19	99.80	114.73
$120,000	2.99	3.99	4.98	8.47	14.46	22.93	33.90	49.85	78.76	108.87	125.16
$130,000	3.24	4.32	5.40	9.18	15.66	24.84	36.72	54.00	85.32	117.95	135.59
$140,000	3.49	4.65	5.82	9.89	16.86	26.75	39.54	58.15	91.88	127.02	146.02
$150,000	3.74	4.98	6.23	10.59	18.07	28.66	42.37	62.31	98.45	136.09	156.45
$160,000	3.99	5.32	6.65	11.30	19.27	30.57	45.19	66.46	105.01	145.17	166.88
$170,000	4.24	5.65	7.06	12.00	20.48	32.48	48.02	70.62	111.57	154.24	177.32
$180,000	4.49	5.98	7.48	12.71	21.68	34.39	50.84	74.77	118.14	163.31	187.75
$190,000	4.74	6.31	7.89	13.42	22.89	36.30	53.67	78.92	124.70	172.38	198.18
$200,000	4.98	6.65	8.31	14.12	24.09	38.22	56.49	83.08	131.26	181.46	208.61
$210,000	5.23	6.98	8.72	14.83	25.30	40.13	59.32	87.23	137.82	190.53	219.04
$220,000	5.48	7.31	9.14	15.54	26.50	42.04	62.14	91.38	144.39	199.60	229.47
$230,000	5.73	7.64	9.55	16.24	27.71	43.95	64.97	95.54	150.95	208.68	239.90
$240,000	5.98	7.98	9.97	16.95	28.91	45.86	67.79	99.69	157.51	217.75	250.33
$250,000	6.23	8.31	10.38	17.65	30.12	47.77	70.62	103.85	164.08	226.82	260.76
$260,000	6.48	8.64	10.80	18.36	31.32	49.68	73.44	108.00	170.64	235.89	271.19
$270,000	6.73	8.97	11.22	19.07	32.52	51.59	76.26	112.15	177.20	244.97	281.62
$280,000	6.98	9.30	11.63	19.77	33.73	53.50	79.09	116.31	183.77	254.04	292.05
$290,000	7.23	9.64	12.05	20.48	34.93	55.41	81.91	120.46	190.33	263.11	302.48
$300,000	7.48	9.97	12.46	21.18	36.14	57.32	84.74	124.62	196.89	272.18	312.91
$310,000	7.73	10.30	12.88	21.89	37.34	59.23	87.56	128.77	203.46	281.26	323.34
$320,000	7.98	10.63	13.29	22.60	38.55	61.14	90.39	132.92	210.02	290.33	333.77
$330,000	8.22	10.97	13.71	23.30	39.75	63.06	93.21	137.08	216.58	299.40	344.20
$340,000	8.47	11.30	14.12	24.01	40.96	64.97	96.04	141.23	223.14	308.48	354.63
$350,000	8.72	11.63	14.54	24.72	42.16	66.88	98.86	145.38	229.71	317.55	365.06
$360,000	8.97	11.96	14.95	25.42	43.37	68.79	101.69	149.54	236.27	326.62	375.49
$370,000	9.22	12.30	15.37	26.13	44.57	70.70	104.51	153.69	242.83	335.69	385.92
$380,000	9.47	12.63	15.78	26.83	45.78	72.61	107.34	157.85	249.40	344.77	396.35
$390,000	9.72	12.96	16.20	27.54	46.98	74.52	110.16	162.00	255.96	353.84	406.78
$400,000	9.97	13.29	16.62	28.25	48.18	76.43	112.98	166.15	262.52	362.91	417.21
$410,000	10.22	13.62	17.03	28.95	49.39	78.34	115.81	170.31	269.09	371.99	427.64
$420,000	10.47	13.96	17.45	29.66	50.59	80.25	118.63	174.46	275.65	381.06	438.07
$430,000	10.72	14.29	17.86	30.36	51.80	82.16	121.46	178.62	282.21	390.13	448.50
$440,000	10.97	14.62	18.28	31.07	53.00	84.07	124.28	182.77	288.78	399.20	458.93
$450,000	11.22	14.95	18.69	31.78	54.21	85.98	127.11	186.92	295.34	408.28	469.36
$460,000	11.46	15.29	19.11	32.48	55.41	87.90	129.93	191.08	301.90	417.35	479.79
$470,000	11.71	15.62	19.52	33.19	56.62	89.81	132.76	195.23	308.46	426.42	490.22
$480,000	11.96	15.95	19.94	33.90	57.82	91.72	135.58	199.38	315.03	435.50	500.65
$490,000	12.21	16.28	20.35	34.60	59.03	93.63	138.41	203.54	321.59	444.57	511.09
$500,000	12.46	16.62	20.77	35.31	60.23	95.54	141.23	207.69	328.15	453.64	521.52

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).

LONG TERM DISABILITY

INSURANCE

The City provides Long Term Disability (LTD) insurance at no cost to benefit-eligible employees through The Standard. The LTD benefit pays employee a percentage of monthly earnings if employee becomes disabled due to an illness, non-work related accident, or injury. Eligible employees are automatically enrolled in this coverage.

CLASS 1 Non-Union Management members other than the Non-Union Safety Management members.

CLASS 2 Non-Union Safety Management members.

CLASS 3 Union member other than the Safety Management members.

CLASS 4 Union Safety members

PLAN FEATURES	INCOME PROTECTION AMOUNT
Employee Benefit Amount	50% Class 1 & 2 members 60% Class 3 & 4 members
Maximum Benefit Amount	$5,000
Elimination Period	90 days
Benefit Duration	Based on the age in which the disability occurs

OTHER INSURANCE PRODUCTS

SUPPLEMENTAL INSURANCE

The City offers a variety of voluntary supplemental insurance through Aflac that may be purchased separately on a voluntary basis and premiums paid by payroll deduction on an after-tax basis, for most products. To learn more about these plans and/or to schedule a personal appointment, contact your local Aflac agent assigned to the City of Miramar. Details regarding available plans and services are also available online at www.aflacgroupinsurance.com.

Available plans include coverages for the items listed below and more.

- Group Short Term Disability
- Group Critical Illness
- Group Hospital Indemnity
- Group Whole Life Insurance
- Group Accident

AFLAC

(800) 433-3036 | www.aflacgroupinsurance.com
Local Representative Sherill Ashley Hernandez | 954-439-4283

LEGAL SERVICES

The City offers voluntary pre-paid legal services through Preferred Legal Plan. Covered services include:

- Free unlimited legal advice via phone consultation
- Free face-to-face consultations with attorneys
- Free review of legal documents (real estate contracts, lease agreements, simple Wills, etc.)
- Notary services for a low cost of **$4.60 per pay period**

This cost is the same for all employees regardless of the number of eligible dependents enrolled in the plan. All premiums will be payroll deducted on a post-tax basis for your convenience. For more information please contact the Preferred Legal Plan Customer Service number at (888) 577-3476 or visit www.preferredlegal.com.

TELEMEDICINE

City of Miramar employees have to around-the-clock access to a doctor, no matter where they are, through Aetna's partnership with Teladoc. This convenient service will connect you to a board-certified doctor by phone or secure video chat. Schedule a doctor visit, manage your medical history, or even send a prescription to the nearest pharmacy – all from the palm of your hand.

Consultation appointments with a doctor only cost your office visit copay level. Be sure to register with Teladoc well before you need any services. To ensure your privacy and security, a detailed registration process is initiated and can take 10-15 minutes. However, once you need the services, you will not have to go through the registration process again.

HOW TO ACCESS TELADOC THROUGH AETNA

Log on to the secure website at https://member.teladoc.com/aetna
Download the Teladoc App from the App Store or Google Play

RETIREMENT PLANS

1 DEFINED BENEFIT (PENSION) PLAN

A pension plan provides a guaranteed benefit at retirement if certain criteria are met, such as years of service. The amount of your future benefit is determined by a formula, based on earnings, length of service and plan multiplier. The benefit you receive is pre-funded by contributions paid by you and the City.

- Participation and membership is mandatory for active, permanent, full-time employees.
- Position classification determines Plan eligibility.
- City contributions vary from year to year based on actuarial valuation.
- Contribution rates, vesting, retirement eligibility and retirement benefits vary by Plan.

For each plan listed, the Summary Plan Description (SPD) provides a brief explanation of the rights, obligations and benefits under each the Plan. However, the Plan Administrators are also available to answer any questions you may have.

PLAN	PLAN ADMINISTRATOR	CONTACT	CONTACT INFORMATION
General Employees' Pension Plan	Benefits USA	Althea Lodge	(800) 452-2454 althea@benefits-usa.org
Firefighters' Pension Plan	Resource Centers	Denise McNeil	(800) 206-0116 Ext. 202 denise@resourcecenters.com
Management Pension Plan Police Officers' Pension Plan	FHA-TPA Benefit Administrators	Yolanda Shea	(800) 707-0501 Ext. 318 yshea@fhatpa.com

2 DEFINED COMPENSATION PLANS

A 457(b) plan is a tax advantaged deferred compensation plan available for state and local government employees. Employees participating in 457 plans are allowed to defer their compensation on a pre-tax basis through regular payroll deductions. Money placed into these accounts grow on a federally tax-free basis until withdrawn.

- Participation is optional.
- Members can elect to participate at any time.
- For 2020, the limit is $19,500.
- Matching contributions are available for Unrepresented employees contributing 3% or more.

The City of Miramar provides two options: Nationwide Investment Services and ICMA Retirement Corporation. Though appointments are available monthly, the Specialists for either plan are available to answer any questions you may have.

PLAN	PLAN ADMINISTRATOR	CONTACT	CONTACT INFORMATION
457(b)	Nationwide Investment Services	Al Pinzon, CRC	(954) 232-7615 PINZONA@nationwide.com
457(b)	ICMA Retirement Corporation	Knickeita Vassell-Bullock	(954)349-1349 kvassell-bullock@icmarc.org

LEGAL NOTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 addresses how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have a right to inspect copy-protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you get access to the information, contact Human Resources.

The HIPAA Privacy Rule was effective beginning April 14, 2003. The Privacy Rule is intended to safeguard protected health information (PHI). The provisions of the Privacy Rule have a significant impact on those who deal with health information and on all citizens with regard to their personal PHI. Our health insurance broker and all our contracted plans adhere to the HIPAA Privacy Rule.

Medicaid and the Children's Health Insurance Program (CHIP)

If you're eligible for health coverage from City of Miramar, but can't afford the premiums, some states have premium-assistance programs that can help pay for coverage with funds from their Medicaid or CHIP programs. If you or your dependents are already enrolled in Medicaid or CHIP, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the employer's health plan is required to permit you and your dependents to enroll in the plan - as long as you and your dependents are eligible, and not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All stages of reconstruction of the breast on which mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses.
3. Treatment of physical complications of the mastectomy, including lymphedema.

Newborns' and Mothers' Health Protection Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family

members. Until you make this designation, your carrier may designate one for you. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

HIPAA Privacy Notice

Please contact HR if you have any questions or need assistance obtaining a privacy notice.

Notice Extension of Dependent Coverage to Age 26 and Enrollment Opportunity

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in medical, dental and vision programs. For more information contact your plan administrator.

Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under Aetna medical program does not apply. Enrollment opportunities for individuals who previously lost coverage due to a lifetime limit are available. For more information contact your plan administrator.

Premium Assistance Under Medicaid & the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of September 1, 2019. Contact your State for more information on eligibility

ALABAMA – Medicaid
myalhipp.com • 1-855-692-5447
ALASKA – Medicaid
AK Health Insurance Premium Payment Program myakhipp.com • 1-866-251-4861 • Email: myakhipp.com Medicaid Eligibility: dhss.alaska.gov/dpa/pages/medicaid/default.aspx
ARKANSAS – Medicaid
myarhipp.com • 1-855-MyARHIPP (855-692-7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado: www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Cust. Service: 1-800-359-1991/State Relay 711
FLORIDA – Medicaid
flmedicaidtplrecovery.com/hipp • 1-877-357-3268
GEORGIA – Medicaid
dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 www.in.gov/fssa/hip • Phone: 1-877-438-4479 All other Medicaid www.indianamedicaid.com • 1-800-403-0864
IOWA – Medicaid
dhs.iowa.gov/hawk-i • 1-800-257-8563
KANSAS – Medicaid
www.kdheks.gov/hcf • 1-785-296-3512
KENTUCKY – Medicaid
chfs.ky.gov • 1-800-635-2570
LOUISIANA – Medicaid
dhh.louisiana.gov/index.cfm/subhome/1/n/331 1-888-695-2447

MAINE –Medicaid
www.maine.gov/dhhs/ofi/public-assistance/index.html 1-800-442-6003 • TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
www.mass.gov/eohhs/gov/departments/masshealth 1-800-862-4840
MINNESOTA – Medicaid
mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp • 1-800-657-3739
MISSOURI – Medicaid
www.dss.mo.gov/mhd/participants/pages/hipp.htm 573-751-2005
MONTANA – Medicaid
dphhs.mt.gov/MontanaHealthcarePrograms/hipp 1-800-694-3084
NEBRASKA – Medicaid
www.ACCESSNebraska.ne.gov • (855) 632-7633 Lincoln: (402) 473-7000 • Omaha: (402) 595-1178
NEVADA – Medicaid
dhcfp.nv.gov • 1-800-992-0900
NEW HAMPSHIRE – Medicaid
www.dhhs.nh.gov/ombp/nhhpp • 603-271-5218 NH Medicaid Service Center at 1-888-901-4999
NEW JERSEY – Medicaid and CHIP
Medicaid: www.state.nj.us/humanservices/dmahs/clients/medicaid/ • Phone: 609-631-2392 **CHIP:** www.njfamilycare.org/index.html 1-800-701-0710
NEW YORK – Medicaid
www.health.ny.gov/health_care/medicaid/ 1-800-541-2831
NORTH CAROLINA – Medicaid
dma.ncdhhs.gov/ • 919-855-4100

NORTH DAKOTA – Medicaid
www.nd.gov/dhs/services/medicalserv/medicaid/ 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
www.insureoklahoma.org • 1-888-365-3742
OREGON –Medicaid
healthcare.oregon.gov/Pages/index.aspx www.oregonhealthcare.gov/index-es.html 1-800-699-9075
PENNSYLVANIA –Medicaid
www.dhs.pa.gov/provider/medicalassistance/health-insurancepremiumpaymenthippprogram/index.htm • 1-800-692-7462
RHODE ISLAND –Medicaid
www.eohhs.ri.gov • 855-697-4347
SOUTH CAROLINA –Medicaid
www.scdhhs.gov • 1-888-549-0820
SOUTH DAKOTA –Medicaid
dss.sd.gov• 1-888-828-0059
TEXAS –Medicaid
gethipptexas.com • 1-800-440-0493

UTAH –Medicaid and CHIP
Medicaid: medicaid.utah.gov • 1-877-543-7669 **CHIP:** http://health.utah.gov/chip
VERMONT– Medicaid
www.greenmountaincare.org • 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid: 1-800-432-5924 www.coverva.org/programs_premium_assistance.cfm **CHIP:** 1-855-242-8282 www.coverva.org/programs_premium_assistance.cfm
WASHINGTON – Medicaid
www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid
mywvhipp.com • 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
www.dhs.wisconsin.gov/publications/p1/p10095.pdf 1-800-362-3002
WYOMING – Medicaid
wyequalitycare.acs-inc.com • 307-777-7531

To see if any other states have added a premium assistance program since September 1, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa
www.cms.hhs.gov
1-866-444-EBSA (3272) 1-877-267-2323,
Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email dol.gov and reference the OMB Control Number 1210-0137.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

The right to COBRA continuation coverage was created by federal law, so that you and your covered dependents may continue your employer-sponsored benefits coverage at full costs (plus an administrative fee). After a qualifying event, COBRA continuation coverage must be offered to each qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost as a result of a qualifying event. If you're an employee, you'll become a qualified beneficiary if you lose your coverage for either of these reasons:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

If you're the spouse/dependent of a City of Miramar employee, you'll become a qualified beneficiary if you lose your coverage under the Plan for any of these reasons:

- Your spouse/parent dies
- Your spouse/parent's hours of employment are reduced
- Your spouse/parent's employment ends for reasons other than his or her gross misconduct
- Your spouse/parent is retired and becomes entitled to Medicare benefits
- You are divorced or legally separated from your spouse
- Child is no longer eligible for coverage under the Plan as a dependent child

MEDICARE PART D

Important Notice from the City of Miramar About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Miramar and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Miramar has determined that the prescription drug coverage offered by the Aetna Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Miramar coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current City of Miramar coverage, be aware that you and your dependents will may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Miramar and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage.

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Aetna changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

-Visit www.medicare.gov
-Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2020
Name of Entity/Sender: City of Miramar
Address: 2300 Civic Center Place, Miramar, FL 33027
Phone Number: (954) 602-383

MIRAMAR

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